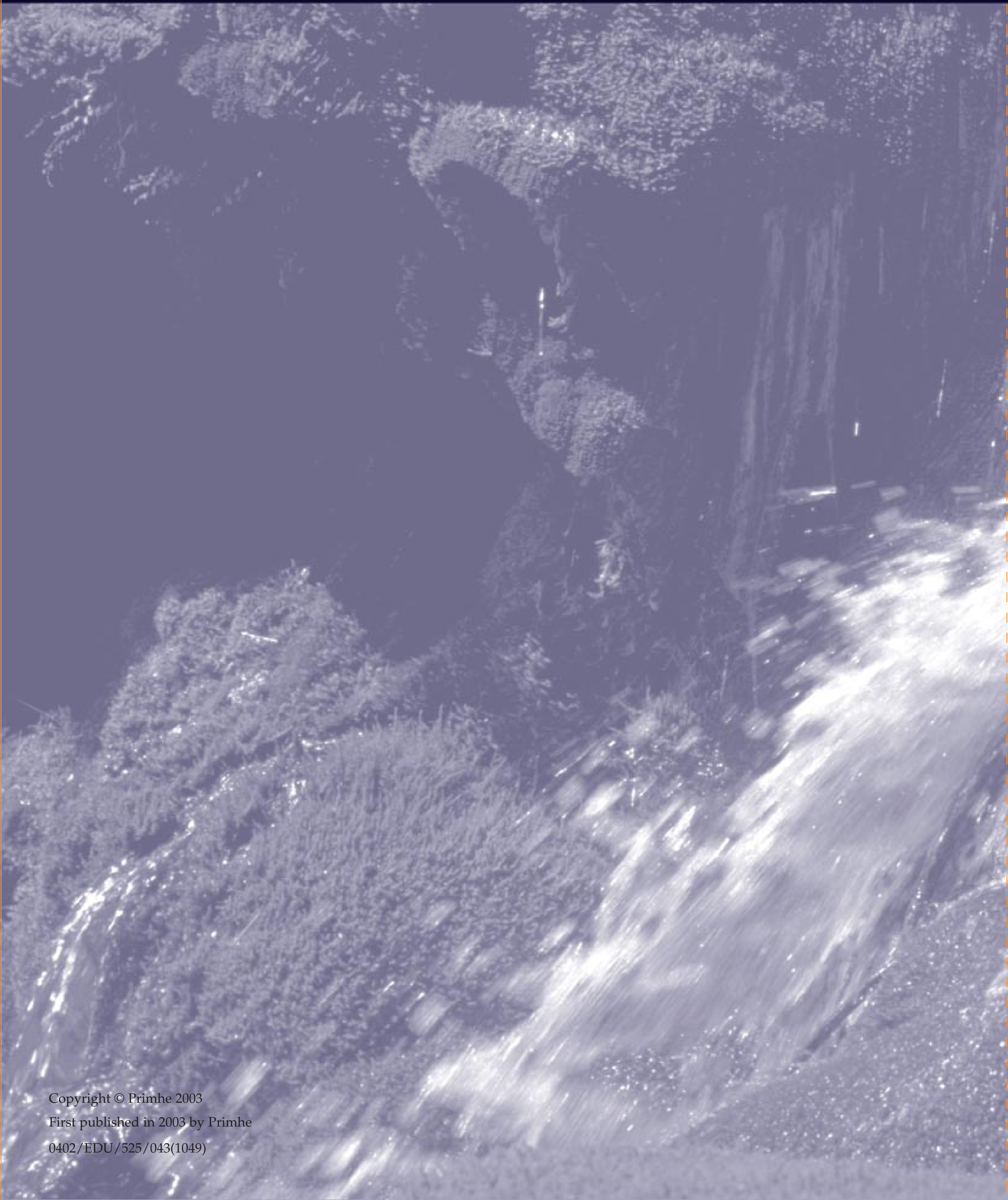

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NHS

National Institute for
Mental Health in England

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PRIMARY CARE MENTAL HEALTH & EDUCATION

Resource Pack

Promoting mental health, cultivating social inclusion and managing mental health problems in primary care

A guide to developing integrated services in line with the national service frameworks for mental health

When you put your hand in a flowing stream, you touch the last that has gone before and the first of what is still to come

Leonardo da Vinci

Promoting mental health and managing mental health problems in the practice and PHCT and in the PCO

Key: ⊕ = Relevant material/resource available on CD

PHCTs can:

Establish relationships on the ground with a range of community-based organisations that aim to support and promote the health and well being of individuals within the community.

Example: Shared care

Facilitation between primary care and the voluntary sector improves outcomes. Findings from a recently reported randomised controlled trial provide evidence of the way in which voluntary sector input benefits people presenting with psychosocial problems in primary care. This study - The Amalthea Project - conducted in Avon with 26 participating general practices, found that people who were referred from primary care to a liaison organisation showed greater improvement in a number of areas, compared to patients receiving routine general practitioner care. Those referred to the project that had better mental health scores (e.g. less anxiety), found it easier to carry out everyday activities and had more positive feelings about general health and 'quality of life' than those who were not referred. (Grant, Goodenough et al 2000)

http://bmj.com/cgi/content/abstract/320/7232/419

http://www.natpact.nhs.uk/connectors/episode_5/05_04myview.php

Practise early intervention

Postnatal depression project in North Essex which focuses on mental health from early pregnancy - a collaborative primary care programme linking community midwives, health visitors and practice nurses.

http://www.ne-mh.nhs.uk/index.htm

Contact:

Maisie Allen, Sheelah Seeley, Mary Armour, Dr S Britten:
North East Essex Mental Health Trust
Minerva Centre for CPD
Harkenwell, St Peter's Hospital
Maldon, Essex, CM9 6EG
Tel: 01621 722912

Work with other agencies

Example: Homestart

This organisation trains volunteer parents who are then matched on a one-to-one basis with other families who are vulnerable. Benefits include improved parental self-esteem, improved physical and mental health and improved management of children's behaviour. Health visitors will normally be aware of local schemes.

Contact: Brian Waller, Homestart, 2 Salisbury Road, Leicester LE1 7QR.
Tel: 0116 233 9955.

http://www.home-start.org.uk/

Suicide prevention: Efforts at suicide prevention should focus on enhancing patients' social and religious networks; increasing the likelihood of early contact with psychiatric services; and decreasing the stigma attached to psychiatric illness.

http://www.rcpsych.ac.uk/press/preleases/pr/pr_398.htm

Developing mental health services in primary care requires a step-by-step approach. PCOs and PHCTs have the organisational structure and resources to initiate and implement a range of activities and programmes which can be designed to support primary care mental health services.

This 'stream' of the resource pack aims to improve client journeys by sharing some practical plans which can inform the development of services that 'make sense' to the client. The domains shown (Fig 1) are suggested as those which can influence positively the mental health of clients (patients/service users/customers), whilst tackling their mental illnesses/'mental health problems':

(Fig 1)

This stream flows through:

- Key principles
- A suggested nine-point plan for Primary Care Organisations
- A suggested eight-point plan for each practice/PHCT (These two plans can be considered alongside each other; they are designed to work together. There are also relevant features contained in the parallel promoting mental health and social inclusion stream)
- The organisational issues needing to be addressed at practice and PCO levels

There are many places to start and practices, PHCTs and PCOs may, for good reason wish to start in different places.

Key principles - what the Primary Care Organisation can do to underpin service provision for those with mental illness/mental health problems:

At an organisational level, it can:

- Ensure that good and effective communication tools (e.g. an intranet) are in place;
- Disseminate information about initiatives before beginning to implement them and put in place a regular, updating mechanism to ensure that the 'information' people (IT and internal and external communications) are aware of all such relevant activities and initiatives (see all promoting mental health stream) and think about dissemination opportunities

  http://www.mind.org.uk/openmind/Extract%20115.htm
- Ensure that all primary care workers feel represented at PCO level;
- Consider appointing a facilitator, or allocating protected time to a member of the PCO staff who has expertise in primary care mental health;

Improve the health of those with schizophrenia and affective disorders

Example: Working with the NICE guideline on schizophrenia

http://www.rcpsych.ac.uk/cru/sts/index.htm

People with schizophrenia and affective disorders have higher rates of comorbid illness, much of which goes undetected. Poor nutrition, poor housing, lack of meaningful activity and poor financial resources make people with severe mental illness more vulnerable to physical health problems. Weight gain, smoking, lack of exercise and poor diet also contribute to very high rates of physical morbidity. There is an urgent need to address the physical health care needs of service users, and to ensure that within primary care, people with a diagnosis are offered the full range of health promotion and prevention services (Cohen 2001). Areas of increased risk include coronary heart disease, diabetes, infections and respiratory disease. (Phelan et al 2001; Brown et al 2000; Harris and Barraclough 1998). ⊕ BMJ

Example: CPN and practice-nurse led weight-management groups

For patients with chronic problems such as schizophrenia and bi-polar disorder, where medication has played a part in problematic weight gain, such groups have proved to be an effective tool for supporting healthy eating, as well as developing other skills such as nutrition awareness, shopping and cooking for these often isolated patients.

⊕ John Pendlebury

Contact:
John Pendlebury
Cromwell House
Eccles
Tel:0161-787-6000

john@pendlebury.freeserve.co.uk

Increase emotional resilience

Example: Reducing the incidence of depression in unemployed people

Group cognitive behavioural therapy is effective in improving mental health and employment outcomes in unemployed adults and reduces the risk of depression in unemployed people. Interventions with a strong focus on job search self-efficacy, social and emotional coping skills and building social support are effective (Price et al 1992).

http://www.doh.gov.uk/jointunit/jipwtw1.htm

This approach also focuses on positive activities and improving social networks. Social support is of great value in reducing the impact of stressful life events, including unemployment. (Bloom 1985; Whelan 1993).

http://www.york.ac.uk/inst/crd/4ment.pdf

PHCTs can also be partners in interventions to reduce stress in the workplace; tackle bullying in schools; combat racism and discrimination; and reduce fear of crime. These types of local partnerships can all contribute to better health, as well as having a direct impact on the prevention of ill health.

http://www.doh.gov.uk/iwl/

http://www.wiredforhealth.gov.uk/

www.antibullying.net/

- Develop self-management, Expert Patient and mutual support programmes in partnership with able and willing patients and tapping into voluntary sector expertise and services where appropriate.

  http://www.primhe.org/downloads/journal/vol_0042/PCMH018.pdf

  ⊕ Alison Faulkner

  http://www.primhe.org/downloads/journal/vol_001and2/miller.pdf

  ⊕ Dr Liz Miller

At PHCT and practice level, it can:

- Work first with those practices that are already mental-health aware. They may have developed models, protocols or audit methods that will help others;
- Start with arrangements for people with schizophrenia and/or psychosis. There will be relatively few patients in this category per practice so the task will not seem too overwhelming. In addition, getting this right means that each practice will establish good communication with the CMHT that serves its population. Collaboration is cool: the most effective services are delivered by people who get on well with, and respect, each other;
- Enable and support team working and an understanding of each other's roles within and throughout the PCO;
- Develop robust and sustainable support mechanisms for primary care staff;
- Enable facilitation between primary care and the voluntary sector;
- Encourage and facilitate research into mental health problems in primary care

  http://www.primhe.org/downloads/journal/vol_0041/PCMH002.pdf

  ⊕ Research;Dr David Baldwin

Managing Mental Health Problems: A suggested Nine-Point Plan for the PCO

Point 1: standards for delivery of care

Ensure that each practice has an up to date register or care database for all patients with severe and enduring mental illness. This will have the following impacts:

Impact on practice	Impact on patient
Current information on areas of clinical concern	Readily accessible and up-to-date information of whom to contact in a crisis
Improved early detection of relapses	Reduced risk of suicide and self harm
Review of investigations to avoid duplication	Reduced loss of clients to follow up
Information source if client is not seen by regular GP	Regular review of both mental and physical health
Improved liaison with CMHTs	Monitoring of side effects
Data source for critical incident analysis	
Appropriate prescribing	
Clarification of prescribing	

⊕ Dr Ayesha Ahmad Public Health Doctor, Croydon

There needs to be clear responsibility for maintaining any register or database. Information on the database needs to be available to local co-ops and others who provide GP out-of-hours services as well as to practice teams and CMHTs.

Example: Mental Health Foundation - Strategies for Living

"Strategies for Living is a programme of work aiming to promote and encourage the development of user/survivor empowerment through research, evaluation and information gathering. We seek to influence a wider audience - of frontline workers, professionals, researchers, policy makers and service users - of the value and significance of 'expertise by experience' and of evidence gained through user-led research and initiatives."

http://www.mentalhealth.org.uk/page.cfm?pagecode=PISL

Example: ISECCA (Improving Self Efficacy, Self Esteem and Confidence of Children and Adults)

Dr Anne Hayden, a GP from Verwood in Dorset, began this in September 1998 as a result of her work in the surgery and after seeing the beneficial effects of a unique surgery based children's counselling service that she set up in 1995. She became aware that if both children and adults could feel better about themselves it would improve not only their emotional wellbeing and mental health, but physical health also. http://www.isecca.org.uk/ (isecca (Dr Bob Gilbertson

Include assessments of mental health needs in patient assessments

The effects of mental illness, substance misuse and progress treatment can be measured in just the same way as people are familiar with in hypertension, diabetes and asthma.

http://cebmh.warne.ox.ac.uk/cebmh/elmh/depression/diagnosis/cage.html

http://www.fpnotebook.com/PSY85.htm

Newer tools, developed in primary care, are also available and in development, and can be used to work with those who have traditionally been regarded as 'treatment resistant'.

⊕ Dr David Beales;'Unexplained symptoms in general practice'

⊕ Dr Ian Walton and Dr Trevor Hadfield;'Empathometrics'

⊕ Dr Ian Cross; 'Depression questionnaire.doc'; 'Assessment emails'

Questionnaires such as the HADS (Hospital Anxiety and Depression Scale) or the GHQ (General Health Questionnaire) can be useful. The results obtained can inform decision-making; however, their use alone makes no difference in itself to outcomes and caution is necessary in using and interpreting them.

http://bmj.com/cgi/reprint/326/7396/982.pdf

It can also sometimes be quite daunting for people when they see that they are iller than they thought.

It is particularly important to be aware of groups within the practice population who may be at particular risk of developing mental health problems, for example: older people; carers; unemployed and homeless people; people with chronic, disabling, painful and life-threatening physical illness; people who are socially isolated.

The CORE Outcome Measure may also be a valuable measure to use because of its free access, its' availability as a computerised system and its' inclusion of a risk assessment for suicide and self-harm.

It might be possible to 'flag up' on the practice computer, people who are in one of the 'at risk' groups to ensure that potential problems are not missed.

Patients presenting with mental health problems should, whenever possible, be assessed in their preferred language. Liaison with community development workers and/or translation services may be necessary.

Point 2: identifying and disseminating good practice

Identify any practices within the PCO who already have protocols and guidelines for any of the conditions listed in the NSF:

1 depression, including suicide risk assessment
2 postnatal depression
3 anxiety disorders
4 eating disorders
5 schizophrenia
6 drug & alcohol misuse

Where protocols already exist, the PCO can ensure that these are shared with other practices. ⊕ Croydon Health Authority

http://bagheera.ncl.ac.uk/PCMH/

Guidelines and protocols are important because they:

- Lay out and define the framework for multi-agency working
  ⊕ Clare O'Flynn
  http://www.primhe.org/downloads/journal/vol_52/nice.pdf
- Improve the safety and continuity of care
- Ensure equity and access

The fact that most people don't follow guidelines or adhere to protocols is often nothing to do with the principles above, but is due to the way in which they will have been engaged with the development process or their own agendas. Professionals, just like patients have their own reasons, at both conscious and subconscious levels for being non-concordant. Get it right and you win, get it wrong and guidelines simply serve as convenient fly swatters.

Point 3: prescribing policies

Develop PCO-wide prescribing policies for antidepressants and benzodiazepines, which are consistent with accepted clinical guidelines (e.g. WHO Guide, NICE), and which involve the most appropriate people in the community (e.g. pharmaceutical advisor, community pharmacist, local hospital pharmacist and service users).

Point 4: mapping provision

- Map the provision of psychological therapies including specialist psychology services and psychology and/or counselling available to each practice. Identify gaps; develop strategy for provision across the PCO. Access to services should be as equitable as possible across all practices in the PCO.
- Identify funding sources in order to extend provision
- Develop access to appropriate therapies for any special groups within the local population e.g. ethnic minority groups, refugees etc.
- Consult the Association of Counsellors in Primary Care for information on setting up managed counselling services for primary care
- Where possible, encourage all local psychological therapy services to use a standardised approach to their audit, evaluation and clinical governance monitoring. One example of an increasingly well-validated approach is the CORE System.

The HADS and the GHQ are available from: NFER-Nelson Publishing Company Ltd, Darville House, 2 Oxford Road East, Windsor, Berks SL4 1BU. These assessment scales are copyright but copies may be purchased in bulk. The HADS and two question test are available for completion online:

http://cebmh.warne.ox.ac.uk/cebmh/elmh/depression/diagnosis/index.html

The CORE Outcome Measure is available free of charge from CORE IMS, 47 Windsor Street, Rugby, CV21.3NZ and inspection copies of the measure can be downloaded from **www.coreims.co.uk**

⊕ CORE-PC

Provide integrated and supportive care

Example: Promoting the mental health of mothers and children:

Thurrock Community Mothers programme

http://www.msfcphva.org/sigs/sigparentingthurrock.html

is a project, now replicated nationally, which uses the expertise of trained volunteers with experience of mothering, to support local parents. There is equal emphasis on developing the skills of the Community Mother volunteers themselves and many move on to other employment opportunities. Community mother programmes have demonstrated positive socio-economic and health improvements for children, parents and volunteers, and have also been successful with traveller communities.
(Johnson and Molloy 1995; Fitzpatrick, Molloy and Johnson 1997; Johnson, Howell and Molloy)

Parents and children receive well integrated support during and after pregnancy

Within the practice this means that there would need to be effective liaison and communication between GPs, practice nurses, health visitors and community midwives. The practice team would also need to be aware of any specific programmes such as Surestart within their area

http://www.surestart.gov.uk/new/default.htm

http://www.surestarthattersley.co.uk/mainframe.html

Example: Health Needs Assessment Tool in South Fenland

Penny Miller, Sure Start South Fenland, Grove House, 74 High Street, Chatteris, Cambs PE16 6NN
Tel: 01354 697906
email penny@surestart-cambs.co.uk
Jon Gumbrell - Director of Programmed Response
Tel: 01372 37107 email jon@programmedresponse.com
Dan Shariatmadari - Co-Director
e-mail: dan@programmedresponse.com
Titterton et al (2002) have reviewed programmes and interventions designed to promote mental health in young children and their families.

Enable people to access other resources

Local stress management, exercise programmes, education and other mainstream opportunities where appropriate

Professionals will need knowledge of:

- Local employment possibilities
  http://www.connexions.gov.uk/
- Leisure and sports services, community activities, cultural activities, faith groups
- Local further education provision especially access arrangements

Point 5: information and dissemination

Consider a PCO-wide approach to the provision of patient and carer information for use in each practice. The simplest way to do some of this will be to ensure that each practice is aware of available resources and how to access them.

There are many local and national organisations that provide leaflets for clients and carers, many of which can be downloaded from the Internet. The following sites have numerous such fact sheets / briefing papers:

Mental Health Foundation:

http://www.mentalhealth.org.uk/index.cfm

Royal College of Psychiatry:

http://www.rcpsych.ac.uk

WHO Guide to Mental Health in Primary Care:

http://www.whoguidemhpuk.org

Northumberland Mental Health NHS Trust:

http://www.northumberland-haz.org.uk/selfhelp/default.htm

It is important that information is available for people whose first language is not English. Information needs to be culturally sensitive and appropriate to the identified needs of the local population including any special groups.User and carer groups, including any groups serving local minority ethnic populations, should be consulted about information needs when PCOs carry out an information/communications needs profile and before unnecessarily re-inventing the wheel

Point 6: staffing skills and workforce planning

Identify optimum skill levels required in each practice to provide a consistent service. Review staffing levels and, if necessary (e.g. for health visitors and district nurses) discuss with local community trust employers. Guidance is available on work force planning on the DOH website. This assists on best practice to implement primary care workforce targets. It is planned that 1000 new graduate primary care workers and 500 gateway workers will be in post by 2004. It is hoped they will support PHCTs in managing and treating people of all ages with common mental health problems. Training programmes are now being established across England (Glasby 2002):

http://www.salomonscentre.org.uk/caspd/training/index.htm

Some practices may benefit from primary care mental health workers, but the role of these workers varies around the country and there is no definitive model.

The National Plan proposes approximately two new primary care mental health workers for each PCO. It is not yet clear what the training, skills and role of these new workers will be; an appropriate role for them may be to assist in the development of registers or care databases and to support clinical audit. Guidance is available from:

www.doh.gov.uk/mentalhealth or **www.nimhe.org.uk**

A framework and list of the practitioner capabilities required to implement the English NSF (and we must hope any others) is available from the Sainsbury Centre for Mental Health:

http://www.scmh.org.uk/8025695100388752/GenerateFrameset1?OpenAgent&doc=wpASTN4XLCX8

There is a current project to determine the core competencies required to deliver national occupational standards in mental health:
http://www.skillsforhealth.org.uk/projects/mentalhealth.asp

Example: Stress workshops and Tai Chi classes for the general public have been set up in several areas. These are usually open access with self-referral but people may also be referred by their GP (alternatively, information may be given by the PHCT with patents choosing whether or not the workshops are appropriate for them).

For more information, contact:
June Brown, Psychology Department, Institute of Psychiatry, De Crespigny Park, London SE5 8AF.
email: June.Brown@iop.kcl.ac.uk

Example: Exercise on Prescription has been tried in several areas for physical as well as mental health.

(see: Health Education Authority Review): 'Effectiveness of physical activity promotion schemes in primary care: a review' available from HEA Book Service on 01235 465565 or 01235 465658.
Also: **www.sportex-online.co.uk**

Example: Prescription for Learning

The National Institute for Adult and Continuing Education has a number of pilot schemes around the country evaluating the use of prescriptions for learning. Initially set up in September 2000 in partnership with the East Midlands Development Agency, Nottingham health Action Zone and Greater Nottingham Learning Partnership, the project based a learning adviser in three GP surgeries. People attending these surgeries could be referred by their doctor or other healthcare staff to see the learning adviser to discuss learning opportunities. For more information, see:

www.niace.org.uk

or phone 0116 204 4200.

⊕ NIACE

Increase social inclusion and participation

Example: Are you speaking my language? Abi Sobowale, a health visitor from Sheffield, worked with mothers to produce a series of leaflets aimed at promoting the mental health of Urdu, Bengali, Chinese, Somali and Arabic-speaking mothers. The leaflets are intended to help professionals discuss mood and emotional health with these clients. They are available, along with posters, from the Community Practitioners and Health Visitors Association (CPHVA).

http://www.msfcphva.org/

Tel: 020 7939 7000. Fax: 020 7403 2976

http://www.mentalhealth.org.uk/page.cfm?pagecode=TIPOEG

http://www.mentalhealth.org.uk/page.cfm?pagecode=TIOSWL

PCOs can use the information from practice training needs assessments to plan PCO-wide training strategies and identify funding sources. Individual PCOs might need to collaborate in some aspects. PCOs may also need to link with CMHTs, education providers and local educational consortia or their successors.

⊕ Trailblazers

http://www.primhe.org/downloads/journal/vol_0061/Buzz%202.pdf

http://www.wdc.nhs.uk/

http://www.sane.org.uk/SANE_Services/Training.htm#PRIMARY%20CARE%20AND%20MENTAL%20HEALTH

http://www.mentalhealth.org.uk/page.cfm?pagecode=PITRCC

Training needs: these should be discussed with local GP tutors, coordinated with personal learning plans and PREP arrangements for nurses. The UKCC requires that all nurses should have a minimum of five days training relevant to their area of practice in each three-year registration period. This five days is a minimum requirement not a maximum, though this is the way it has often been interpreted in the past.

Plan training and identify sources of expertise.
Potential funding sources include local educational consortia or their successors, and the pharmaceutical industry. Guidelines from the voluntary sector are available on how best to engage, and work with, the industry and are easily adapted:

http://www.lmca.demon.co.uk/docs/pharmgds.htm#introduction

Point 7: information for patients

In collaboration with local secondary care services, PCOs can provide each practice with up to date information about all local services for people with mental health problems (e.g. wall charts, directory, on-line information).

Several areas have commissioned their local MIND organisation to carry out this work. Example:

http://www.mindincroydon.org.uk/mindguide/index.htm

From a mental health promotion perspective, it is also important for practices to have information about those local agencies that provide support for people with emotional and social difficulties. Examples are:

- Relate for relationship difficulties (all couples including gay relationships).
- Cruse Bereavement Care.
- Citizens Advice Bureau.
- Debt counselling services.
- Housing agencies.
- Support for parents and children.

Have a means to identify people on your list who are carers and provide appropriate support

Example: The Southern Staffordshire Carers Project (1997)
Primary Health Care Response to Carers Project (1997). 131-141 North Walls, Stafford, ST16 3AD recommended that:

- All new patients to a practice should be asked whether they have a caring role;
- Carers should have their own health and support needs regularly assessed (Carers are entitled to have these assessments);
- Carers should be involved in planning for the patient's needs;
- There should be some means of identifying carers in records;
- Appointment systems could be modified to help cut down waiting times;
- Carers' information should be available in all waiting rooms and its value should be promoted to carers, including information about assessment of their own needs;
- Establishment of a carers' support group within the practice may be useful;
- A designated member of staff should have responsibility for carers' issues.

Have your training and personal development needs met

All practice teams need to have practice education plans as well as personal development plans for all staff, including administrative staff. These plans need to include knowledge of:

- local ethnic minority populations served by the practice including any relevant cultural issues;
- knowledge of refugees and asylum seekers in the area, and sources of help for these groups;
- working with people who misuse alcohol and drugs including early intervention; dealing with aggressive, anti-social and violent behaviour;
- local support agencies and community organisations;
- local procedures for dealing with domestic violence and child protection;
- training in local anti-discrimination policies.

Have access to information

Access to information about local and national services and support agencies for people with mental health problems, and for people with a range of social, emotional and physical health problems which are known to predispose to mental health problems, can be made available to all staff and patients. This information can be displayed on the practice notice board along with other health information. This might help to 'normalise' mental health problems and reduce stigma. Leaflets about depression and anxiety and other problems can be freely available for patients as with other health topics. There will be other means of making information available in such a way as not to exclude people in particular groups.

http://www.rcpsych.ac.uk/info/index.htm
http://www.wrecked.co.uk/noframes/index1.html
http://www.trashed.co.uk/
http://www.teachersupport.org.uk/index.cfm?a=182
http://www.connects.org.uk/conferences/

Point 8: crisis and liaison services

With local A&E service and crisis services, develop a protocol for liaison with all primary care teams about people who self-harm; this may include developing means of support for patients and carers at times of crisis.

Close links and communication with local CMHTs are vital

http://www.mhprimarycare-ney.nhs.uk/mhmatrix2.html

⊕ Denise Fisher

At a PCO level an interface policy could be developed outlying:

- What to do out of hours
- Roles and responsibilities
- Criteria for referral and content of referrals
- Distinguish between urgent and emergency
- Shared prescribing
- CPA
- Physical health

Point 9: Evaluation and audit

Develop interesting evaluations and local audits to monitor and evaluate the implementation of the action plans. (See Stepstone 5).

A suggested eight-point action plan for Practices and Primary Health Care Teams

Each primary health care team (PHCT) within the PCO would have:

1. Register of patients with severe and enduring mental illness agreed with community mental health teams.
2. Protocols for depression including suicide risk assessment, postnatal depression, anxiety disorders, eating disorders and schizophrenia. It is also helpful to have protocols for drug and alcohol misuse.

   http://www.primhe.org/downloads/journal/vol_52/depression.pdf

   ⊕ Dr Ian Shaw and Dr Huw Middleton

   http://www.primhe.org/downloads/journal/vol_0051/gerada.pdf

   ⊕ Dr Clare Gerada

   http://www.primhe.org/downloads/journal/vol_0051/keen.pdf

   ⊕ Dr Jenny Keen
3. Practice policies for prescribing psychotropic medication consistent with accepted clinical guidelines.
4. Access to structured psychological therapies.
5. Patient and carer information on common mental health problems.
6. Appropriate mental health training for all staff - clinical and administrative. A nominated member of the PHCT to acquire the skills and knowledge about mental health benefits and allowance. Every PHCT needs to know about Benefits, Mental Health Assessment, Disability Living Allowance and Return to Work schemes.
7. Easily accessible information about local services, including carer support.
8. Effective liaison with A&E departments, community mental health teams (CMHTs), police and crisis services particularly about people who self-harm.

   http://www.primhe.org/downloads/journal/vol_0043/PCMH010.pdf

   ⊕ Malcolm Firth and Carolyn Chew-Graham

   http://www.primhe.org/downloads/journal/vol_0061/Stephens.pdf

   ⊕ Dr Mike Stevens

Staff wellbeing

Access to health care and support for all staff, including those with mental health problems. PCT human resources staff might be able to help practices develop good employment policies.

It may be of use to undertake staff well-being surveys to identify the general psychological health of the organisation, and specific individuals who may benefit from staff support services.

Such a survey was successfully undertaken by the Royal College of Nursing in 2002.

'Working Well: a call to employers'

http://www.rcn.org.uk/publications/pdf/working_well_survey_inside1.pdf

http://www.nyx.org.uk/improvingpractice/northumberland/feb2003/personaladvisor.htm

However busy you and your team are, you need to set aside time for yourselves. Here are some examples of how teams can make time for themselves:

- Regular lunches. Ask someone to come in from a local organisation (school, social services, drug action team, African lunch club) to give a talk about what they are up to and how it relates to your service. Make it a culture of your workplace that everyone attends - no-one is sitting in their room catching up on the paperwork.
- Go out to eat at a local restaurant once a quarter. Paid for out of practice funds.
- Practice outing such as a picnic or boat trip once a year, with partners, children and other family members.
- Each member of the team has a nominated person to whom they would turn in the first instance if in trouble, feeling unwell, worried about something.
- Each member of the team to be registered with their own GP (not someone in the practice...unless you work on Mull!)

  http://bmj.com/cgi/reprint/319/7210/605.pdf

Give support and ensure that people experiencing life transitions have access to appropriate support and information (see also below)

Example: Open access nurse led clinics for people with depression or experiencing emotional difficulties

A dedicated phone line was manned by practice nurses in Lambeth service. People could be referred to a GP where necessary.

Contact:
Professor André Tylee
Professor of Primary Care Mental Health
Institute of Psychiatry
P028 - David Goldberg Building
Health Services Research Department
De Crespigny Park
Denmark Hill
London SE5 8AF
Tel: 020 7848 0150 or
email: a.tylee@iop.kcl.ac.uk

In addition, it is advisable for primary care teams to develop:

- Explicit methods of communication within the team
- Support for all members of the primary care team

The following is a step by step guide to help put the nine-point plan into practice.

An evaluation form to monitor change is included in Stepstone 5

1. Setting up a register of patients with severe and enduring mental illness.

A case register offers the most pragmatic way of developing a 'care database' for a group of highly vulnerable people. In order to do this effectively practices should designate a member of staff to take responsibility for setting up and maintaining the register. If a register is not felt appropriate other means of identifying these patients and their carers needs to be established.

Practices may already have people with experience in setting up registers for a chronic disease or age/sex register. (PCT;'Charnwood and North West Leicestershire PCT'; 'Developing an SMI Register.doc'). Setting up a register will necessitate liaison and collaboration with the appropriate community mental health team (perhaps via a link worker).

http://www.primhe.org/downloads/journal/vol_0061/Buzz%201.pdf

⊕ St Alban's Medical Centre, Bournemouth

This person should:

- Establish with the mental health lead of the PCO which definition of severe and enduring mental illness is to be used locally (see Appendix 2).
- If possible, identify from the practice computer, or other source, all patients who meet the criteria for severe and enduring mental illness.

Or

- Make a list of all patients who have a care programme under Care Programme Approach (CPA) arrangements. If you do not have this information the local CMHT will be able to assist.

And

- Identify all patients with a diagnosis of schizophrenia or psychosis who are receiving depot neuroleptic medication from a practice nurse or other professional within the practice.
- Identify all patients on your repeat prescribing list who are taking antipsychotic medication or other long-term psychotropic medication (e.g. for severe chronic depression).

Drug based searches are often the easiest to undertake, but be aware that some patients may receive their medication at specialist clinics or day centres outside the practice.

Compare the practice list with the list of patients from the practice who are currently under the care of the local CMHT. Both lists should be reviewed by the CMHT and a GP from the practice in order to arrive at a definitive list of people who meet the criteria for severe and enduring mental illness. These may not be the only patients from the practice receiving care from the CMHT. Some clients do not attend the CMHTs, around 30% of SMI clients will be only under the care of the PHCT (Kendrick et al 2000).

Suitable patients will meet the following criteria, but assessment would be required in all cases:

- Their problems are affecting their ability to cope with everyday life, or the quality of their life and relationships.
- Their problems will be causing current distress.

Indications of whether potential clients will be able to use counselling effectively are:

- Being able to engage in conversation and willing to disclose personal information
- Having the capacity for reflection and some motivation for change
- Being willing to make a regular commitment to attend appointments.

The very fragile may well find counselling too challenging, as may those who have too much invested in staying the same.

Clients amenable to counselling or psychotherapy in primary care are likely to be those in the following categories:

- Pathological bereavement
- Coping with injury or illness
- Depression - reactive, circumstantial
- Developmental or life crises
- Appropriate emotional, physical or sexual abuse issues
- Family relationship issues
- General anxieties and phobias
- Lack of direction, alienation, existential problems
- Loss, eg relationship, employment, health etc.
- Self-image and identity issues
- Stress and trauma - pre and post event
- Issues of sexuality

Not all clients will be suitable for counselling within the practice; Specialist skills are required for the following:

- Sexual dysfunction
- Poor communication ability
- Self-destructive behaviour which, over time, has shown very little change eg prolonged substance misuse, eating disorders
- Moderate to severe mental illness/disorder
- Severe challenging behaviour eg aggression, violence, severe learning disabilities.

Source: Association of Counsellors and Psychotherapists in Primary Care

http://www.cpc-online.co.uk/

If there are any patients on the list with a diagnosis of schizophrenia or psychosis in the notes who are NOT on neuroleptic medication, a GP should be asked to check:

- Is the diagnosis correct?
- Is the lack of medication intentional?

For each patient, the register should include:

- CPA arrangements
- Name of care co-ordinator
- How to recognise a crisis or impending relapse
- What to do/who to contact in a crisis (agreed with patient and carer).
- Review arrangements and dates, including physical health care, including a recall system
- Responsibility for prescribing

The above information can be found on CPA documentation

http://www.doh.gov.uk/mantalhealth/auditpack.pdf

⊕ DoH;'CPA';CPA Audit Pack.pdf

All patients with severe and enduring mental illness should have access to secondary (specialist) services when required.

NB: This information needs to be available to local co-ops and others who provide out-of-hours GP services as well as practice teams and CMHTs.

2. Guidelines and protocols

The PCO should have guidelines for managing mental health problems already in place. If the practice does not have access to them contact the Mental Health lead for your area to obtain them. A number of PCOs are working towards protocol development. Guidelines are what they say they are and following them Is optional; protocols are not optional, they are a set of set of instructions detailing what *must* be done in any particular set of circumstances.

Your mental health and/or clinical governance lead should be able to assist in their implementation. Educational, training and interactive workshops and opportunities with appropriate facilitation are important here. It also bears repeating that people, practices and PHCTs have their own Maslow's hierarchies of need **http://www.businessballs.com/maslow.htm** and failure to engage with your agenda can be due to issues around involvement, ownership, buy-in, acopia, their own justified major pre-occupations or concerns, workload, stubbornness and sheer petulance! Building trust has a lot going for it.

http://www.primhe.org/downloads/journal/vol_003/gardiner.pdf

⊕ Patti Gardiner

How to write your own

Increasingly, guidelines can be seen as catalysts to the development of integrated care pathways and a whole-systems approach centred on the person using services. If developed inclusively they actually enable the management of mental illness within a primary care team and between the primary care team and the community mental health team, since they act as a reminder of what everyone has agreed. The best ones involve service users and carers in their design and continued monitoring. They should not straight-jacket anyone and flexibility is the key. For example, they cannot do justice to the variety of people or to their, or our, day-to-day variability. You might be having a bad day and need to refer someone this week who you were able to cope with last week - the exercising of our core competencies does require our own capability to do so on the day?

The potential for the PCO

Mental health promotion is not currently part of quality incentive schemes for GPs and mental health promotion targets are not included within clinical governance and quality control for primary care. In fact, many of the potential funding streams for health activity are not in NHS budgets at all. In many respects, health is no longer exclusively the NHS's 'business'. By doing the following, however, and looking at other examples in this pack, the PCO can help to establish mental health promotion within the public health and commissioning framework of primary care:

- **Linking** through to local strategic initiatives which have strong mental health promotion potential, e.g. Community Strategies

  http://www.local-regions.odpm.gov.uk/pcs/guidance/,

  Local Agenda 21 Strategies

  http://www.scream.co.uk/la21/,
  Community Safety Partnerships

  http://ww2.auditcommission.gov.uk/publications/com_safty.shtml

  Sure Start Programmes

  http://www.surestart.gov.uk/new/default.htm

  Lifelong Learning Development Plans

  http://www.lifelonglearning.co.uk/iln7000/iln7009.htm

  Local Strategic Partnerships

  http://www.neighbourhood.gov.uk/publicationsdetail.asp?id=89

  and Connexions

  http://www.connexions.gov.uk/
- Targeting primary prevention at excluded groups such as homeless people or specific minority ethnic groups, especially those who have difficulty in accessing primary care;
- Supporting employment schemes in which mental health service users are employed and addressing this issue within the PCO;
- Employing community development link workers, primary care workers or mental health facilitators to link with local community leaders, politicians, employers;
- Addressing the needs of vulnerable groups, for example women who may be experiencing domestic violence, carers, lone parents and the physical needs of people with long term mental health problems;
- Challenging stigma and discrimination and promoting local community learning about mental health and mental illness.

  http://www.rcpsych.ac.uk/campaigns/cminds/index.htm

  ⊕ RCPsych;'Changing Minds'
- Innovating and working in new ways; following the principle of deploying people with the appropriate skills to meet the needs and developing integrated services, many of them delivered by the voluntary sector.
  http://www.hm-treasury.gov.uk/spending_review/spend_ccr/spend_ccr_voluntary/spend_ccr_futurebuildersfaqs.cfm
  ⊕ Sarah Cowley. ⊕ Healthy Schools

Three functions have been identified for link workers in primary care:

- Providing care
- Increasing the capacity of the Primary Health Care Team
- Improving the flow of information between primary care and various agencies.

Steps to consider when writing a protocol include:

- Choose the condition for which the protocol is to be written.
- Identify any protocols that might already exist either locally or nationally
- Identify a group of people within the practice (or PCO, or group of practices) to take the process forward. This group should include representatives of all professionals involved in the care of this group of patients, a member of the administrative staff, a representative patient or user, a carer. A group facilitator may be needed.
- Agree which clinical guidelines are to form the basis of the protocol (eg WHO Guide - see Introduction).
- Starting with the first contact, write down the care pathway that the patient should follow. This might include:
  - Assessment methods including use of assessment tools.
  - Diagnostic criteria including levels of severity.
  - Treatments to be offered according to local availability.
  - Information required for patient and family.
  - Follow up arrangements.
  - Criteria for referral to other clinicians e.g. nurse to GP, practice based specialist such as counsellor or to secondary care.
- Agree a method for implementing the protocol in practice.
- Implement the protocol.
- Audit how well the protocol is working (or not!)
- Review and update in light of the audit.

⊕ Examples of Guidelines and Protocols for Anxiety, Depression, Schizophrenia, Psychosis Management and Treatments are on the CDROM in the following folders: Dr Mark Agius and Dr Olwyn Gallagher; Dr Tim Webb; PCTs (eg Croydon) and NHS Trusts (eg South West Yorkshire Mental Health Trust)

The Orchard Model- A systematic model for follow up of patients with depression

This model, pioneered at the Orchard Medical Practice, Ipswich, is designed to be used by a practice nurse in collaboration with the patient's GP. It assumes that the patient is initially assessed by the GP and referred to the nurse for follow up.

Aim: To improve the care of patients with depression in primary care.

Objectives:

- Identify patients with depression using a suitable assessment tool.
- Assess, plan and implement programmes of care.
- Supervise patients taking medication to maximise treatment adherence.
- Monitor mood and suicide risk.
- Co-ordinate care in collaboration with other clinicians.

At patient's first visit, the clinician should:

- Administer appropriate questionnaire (see appendix 4)
- Observe and record:

  Mood

  Severity

  Duration

  Physical symptoms

  Social network and difficulties

  View of self

  Suicidal thoughts
- Assess needs e.g. problem solving, information regarding medication, voluntary agencies/self-help group, relaxation, general health advice.
- Negotiate care plan.
- If clinician managing the care is not a GP, refer back to prescribing doctor for follow-up in 2-4 weeks (earlier if suicidal ideas are present).

Community bridge building, whereby people with mental health problems can be reconnected with aspects of their lives, is one important example of engagement. A dedicated worker has the role of building local opportunities around the needs of individual service users and then providing the support and assistance necessary for them to make use of those opportunities.

Community development workers, and community projects which support local services, can challenge discrimination and stigma locally, and are important to the development of social capital at neighbourhood level.

In the case of black and ethnic minority groups, the main aim is to build on their inherent strengths and capacity when dealing with mental health issues within the communities themselves. The idea that communities or people in general should reclaim responsibility and ownership for their health and health care has its roots in both self-help and public health movements as well as in the traditions of many ethnic and minority groups.

The success of community mental health programmes, which form the basis of current priorities in mental heath in this country, will be dependent upon strategies that facilitate the involvement of communities in mental health. It is expected that community development workers will make this happen through enhancing community participation and ownership.

The benefits of mental health promotion are wide-ranging, because healthy minds equate to personal health and wellbeing, which themselves, in turn, deliver healthy communities.

Whilst the promoting of mental health has a role in preventing mental health problems, notably anxiety, depression, drug and alcohol dependence and behavioural disorders, it also has a wider range of health and social benefits, including improved physical health, increased emotional resilience, greater social inclusion and participation and higher productivity. Interventions to reduce stress in the workplace, to tackle bullying in schools, to tackling racism and discrimination, to increase access to green, open spaces and to reduce fear of crime all contribute to health gain through improving mental well-being, in addition to any impact they may have on preventing mental disorders.

The PCO can:

Perform local area health needs assessments

Public health departments in collaboration with the public health departments of government offices, especially mental health leads, will be able to identify, with reference to the wider health inequalities agenda, issues relating to mental well being e.g. areas of social deprivation, high crime; unemployment; refugees and asylum seekers; homeless people and rough sleepers; drug and alcohol misuse issues. This information will be available for the whole area covered by the PCO, but also at the level of individual communities. Statistical information will normally be included in a mental health strategy for the area and can be developed with, and published, in partnership with the local authority.

⊕ NHS Trusts; 'Gloucester Partnership NHS Trust'

http://www.partnershiptrust.org.uk/partnership8177.html

http://hcna.radcliffe-oxford.com/main.html
⊕ HCNA(Health Care Needs Assessment).Radcliffe

Northamptonshire Joint Mental Health Promotion Strategy 2002-2005. Northamptonshire Health Authority. Tel: 01604 615161. Fax: 01604 615149.

A Strategy for Mental Health Promotion in North and Mid Hampshire 2002-2012. (2002) North and Mid Hampshire Health Authority

http://www.hants.gov.uk/health-promotion/

A local audit of mental health need, and organisations available to meet the need is vital if any coherent strategy is to be developed and implemented.

⊕ Leicester City PCT; 'Mental Health Baseline Assessment.doc'

Thereafter:

- Routine follow-up approximately monthly. At each follow-up, assess:
  Mood (re-administer questionnaire at appropriate intervals)
  Treatment adherence and any side-effects from treatment
  Suicidal thinking
  Other symptoms
- If the clinician managing the care is not a GP, refer back to GP if symptoms are worse, suicidal ideas present, drug side effects intolerable, non-adherence to medication.
- All in-house protocols should include criteria for referral to other agencies such as secondary care services. Referral criteria will probably be agreed with secondary care at PCO level, but all practices need to be aware what they are.
- **Suicide risk assessment protocols require clear agreement within the primary care team and with secondary care services. It may also be advisable to consider formal arrangements for debriefing or critical incident analysis following a suicide. If protocols are negotiated at PCO level, all practices must be aware of the agreed arrangements.**

  ⊕ Aislinn Enright; 'Assessment of Suicide'.doc

3. Prescribing policies

Prescribing policies should be aimed at meeting the needs of individual patients. They need to be developed in collaboration with pharmaceutical leads of PCOs and pharmaceutical advisers. Prescribing policies should be consistent with up to date clinical guidelines e.g. NICE guidelines.

http://www.windrush.net/nice/welcome.htm
British Association of Psychopharmacology Guidelines

http://www.bap.org.uk/consensus/antidepressants.html
WHO Guide

http://cebmh.warne.ox.ac.uk/cebmh/whoguidemhpcuk/introduction.html

Criteria which might be included in a policy:

- Prescribing indications.
- Medication appropriate to individual patient circumstances.
- Cost effectiveness data.
- Recommended length of course.
- Follow up arrangements.
- Initiation and discontinuation regime.
- Lines of responsibility.

This site is a UK multi-page hospital pharmacy web-site. You can find out more about drug treatments that are prescribed for mental health needs:

http://www.nmhct.nhs.uk/pharmacy/

The results from needs assessment and audits will need to be taken into account when developing local health delivery plans and will help to inform the commissioning process.

http://www.wales.nhs.uk/lhg/home.cfm?ORGID=260

⊕ PCOs;'LHBs';'Pembrokeshire LHB';'Pembrokeshire Health and Social Care Plan'

Appoint someone, or team, to have responsibility for implementation of a mental health action plan

A team approach may be taken, led by an executive director, working with, for example, a GP with special interest (GpwSI)

http://www.gpwsi.org/mentalhealth/index.htm

http://www.doh.gov.uk/pricare/gp-specialinterests/mentalhealth.pdf

⊕ DoH;GPwSI

and/or a nurse consultant. It might also be helpful to have support from one or more interested non-executive directors.

Such a team will have close working relationships within the PCO with, for example, clinical governance, workforce development and quality team development leads, and externally with community mental health trusts, hospital trusts, local authorities and the voluntary sector. Board level involvement can help to ensure that mental health is considered as an integral part of all developments.

Collate and keep up to date information on public health, national and local support agencies and programmes

PHCTs benefit from having information from the public health department relating to their own catchment areas and local communities.

http://www.cravenmentalhealthdirectory.co.uk/index.asp

⊕ Craven Mental Health

Variations in consultation rates, referral to specialist services, use of psychotropic drugs for mental health problems in different ethnic groups should be audited annually.

PCOs, PHCTs, service users, carers and all relevant organisations and partners involved in mental health promoting activities and delivering care for those with mental illness benefit from being able to read about what others are up to around the UK. It is therefore important for the 'information people' in the PCO/Council/Trust to be 'locked in' and informed about such activities regularly, so that they are clearly signposted and showcased on the website and in all local and national communications, bulletins and newsletters.

http://www.hackney.gov.uk/index.htm

⊕ City and Hackney Communication Information System

http://www.hattpin.org.uk/default.htm

⊕ Hattersley Public Information Network

It is particularly important that those organisations with a remit to enable the national 'joined-up ' agenda are also informed of such activities.
It is good for people to know that their hard work is being recognised, appreciated and enabling others; this delivers on promoting mental health in the NHS workplace.

http://www.primhe.org/lunbeckawards/2002photos.htm

http://bagheera.ncl.ac.uk/PCMH/

http://www.nimhe.org.uk/

http:// www.natpact.nhs.uk/

http://www.sdcmh.org.uk/home.htm

4. A Model for structured access to psychological therapies.

Tier One	Adjustment disorders (See WHO Guide). Simple grief reactions. Mild depression & anxiety.	Support, reassurance and advice. Support and reassurance Problem solving. Bibliotherapy http://cebmh.warne.ox.ac.uk/cebmh/elmh/depression/treatment/bibliotherapy2.html#what Brief structured visits by HV for postnatal depression Information about access to community services e.g. Relate, Cruse, CAB, Social Services, self-help groups and help lines.
Tier Two	Mild to moderate depression, anxiety disorders, chronic social difficulties, relationship problems, divorce and separation, bereavement.	In-house counsellor, psychotherapist or psychologist providing brief structured therapies according to training. In-house anxiety management groups **or** In house primary care mental health worker according to training **or** Access to PCO managed counselling/psychology service providing brief, time limited therapies.
Tier Three	Moderate to severe depression, severe anxiety disorders. Other mental illness.	Access to specialist clinical psychology services and/or clinical nurse therapists according to local referral criteria

http://www.primhe.org/downloads/journal/vol_52/swindon.pdf

⊕ Liz Howells and Annette Law

http://www.mind.org.uk

http://www.mentalhealth.org.uk

http://www.virtuall.org - a charity combining 'e' based learning and practical development programmes with the aim of achieving better mental health for London.

PHCTs require up to date information about national and local support agencies and programmes relating to mental well-being from both voluntary and statutory agencies as well as sources of help for people experiencing mental health problems, and for those who are at risk because of social or emotional difficulties.

As a start, all practices could be supplied with copies of 'Contact - a directory for mental health', published by the Department of Health in association with Focus on Mental Health. This directory is currently being reprinted. The new version will list over 140 organisations providing help and information and will be more user-friendly than the original version. Contact will be available free from: DoH Publications: 08701 555455

When collating a local directory of services someone needs to take/be given responsibility for managing it.

Such a directory needs to include information about all services, both for people with mental health problems and people who are experiencing social and emotional difficulties. In promoting social inclusion it will be important that it contains details of mainstream and community organisations and projects as well as details of agencies specifically targeted at people with mental health problems.

A directory can be paper-based, on disk, on a local intranet, or any other way which seems appropriate to local circumstances, but whatever form it takes, it would need to be maintained and kept up to date.

Directories should contain details of what each agency provides, target clientele, contact details and, where appropriate, referral criteria. Ideally this would be a collaborative project between health, social care and the voluntary sector and local business in any area. In many cases directories will already exist but it may be necessary to review the information they contain and how and to whom they are distributed.

⊕ NHS Trusts; 'Manchester Mental Health and Social Care Trust'

http://www.mmhsc.org.uk/index.html

⊕ Avonweb Public Site; 'Avon Mental Health'

http://www.avon.nhs.uk/mentalhealth/

South Tyneside PCT has a strategy developed through collaboration

http://www.healthpromotion.demon.co.uk/page/mentalhealth.html

⊕ PCOs;'PCTs';'South Tyneside PCT'

Shropshire has a manual and a web site dealing with many of these issues. It is co-ordinated by a network of voluntary agencies around the county and funded by Shropshire County Council and Shropshire Health Authority. It is called Health and Care Information in Shropshire and can be viewed at

www.askollie.org.uk

Herefordshire Mental Health is an online reference guide to mental health services in Herefordshire.

http://www.herefordshirementalhealth.info/mhpromo/mhpromo_index.shtml

Lampdirect is a gateway to information on mental health throughout Leicester. Leicestershire and Rutland

http://www.lampdirect.org.uk/default.asp

⊕ LAMPDirect

The boundaries between each tier will not be the same for each practice in the PCO, at least at first, but the aim should be to move towards consistency. Patients should be able to expect a similar (though not necessarily identical) level of service whichever practice they attend.
It is beneficial for someone in the surgery to develop a database on local counselling information including voluntary and private. It is worth contacting, inter alia:

- Local MIND / Depression Alliance/Rethink/Penumbra/Sane for information on voluntary services. (Voluntary Third Sector Organisations)

  http://www.mind.org.uk/

  http://www.depressionalliance.org/

  http://www.rethink.org/

  http://www.penumbra.org.uk/

  http://www.mdf.org.uk/
- Counsellors and Psychotherapists in Primary Care:

  http://www.cpc online.co.uk/
- British Association for Counselling and Psychotherapy have a list of accredited private counsellors:

  http://www.bacp.co.uk/seeking_counsellor/seeking_counsellor_frameset2.htm
- United Kingdom Council for Psychotherapists can email a list of local private therapists: **http://www.ukcp.org.uk/**

Also, details of local and national helplines:

http://www.sane.org.uk/SANE_Services/SANELINE.htm

5. Patient and carer information.

The WHO Guide includes a disk with sample patient information sheets for a variety of mental health problems. These are also available on the web site and may be printed off to give to patients. (Voluntary ⊕ Third Sector Organisations)

Many national organisations such as Depression Alliance, Sane, The Samaritans Rethink, MIND and the Mental Health Foundation produce a wide variety of excellent quality literature for the public. Audiotapes and videos are also available.

Provision of patient and carer information can be co-ordinated at PCO level

6. Mapping PHCT skills, training and support needs.

There are a range of new and stimulating methods and techniques available for dealing with the whole spectrum from major psychiatric illness to so-called 'worried wellness', together with a wide range of modalities for learning about them, from formal courses, through CD-ROMs to web-enablement. Such methods include Cognitive Behavioural Therapy

http://www.calipso.co.uk/mainframe.htm (Calipso Neurolinguistic Programming

⊕ Practical-eq
http://www.primhe.org/downloads/journal/vol_0051/buzzsmith.pdf

and Problem-orientated and Solution-focussed Therapies
http://www.brieftherapy.org.uk/aboutbrief.htm (Solution Focussed Therapy

Laminated posters showing contact details for some of the most commonly used local agencies can be useful to display in supermarkets, libraries, post offices, surgeries, clinics, health centres, social service departments, A&E departments and waiting rooms. (Maunder et al, 2002)

West Wales Action for Mental Health, Llys Steffan, Temple Terrace, Lampeter, Ceredigion, SA48 7BJ; Tel: 01570 422559; Fax: 01570 422698; email: wwamh1@btinternet.com

Act as an imaginative broker of arrangements that will foster mental health promotion (and social inclusion)

Support networks/self help:

Primary care has a role in strengthening access to self-help and support networks by ensuring better links between primary health care and sources of information and support in the community.

http://www.creativecommunities.org.uk/frames.htm

⊕ Centre for Creative Communities

http://www.dfes.gov.uk/communitychampions/about/index.cfm

⊕ DfES; 'Community Champions Fund'

Effective interventions include the promotion of self-help, advocacy, neighbourhood and voluntary activities, as well as structures that facilitate community planning and local decision-making in the provision of services and maximal involvement of people using services in that community and their carers.

http://www.designedtoinvolve.org.uk/home.htm

⊕ Designed to Involve.org.uk

Self-help support such as basic psychosocial information, relaxation advice plus referral to a self help group is as effective as cognitive therapy and medication in treating generalised anxiety disorders (Cuijpers 1997)

http://www.natpact.nhs.uk/connectors/episode_5/05_pctview.php

Encouraging and nurturing creativity in the arts has a lot going for it:
http://rcpsych.ac.uk/campaigns/2001/index.htm

⊕ Cumbria Arts and Health Group

http://www.artworksinmentalhealth.co.uk/index.asp

⊕ Art Works in Mental Health

http://www.cumbria.com/edenarts/projects.htm
http://www.northcumbriahealth.nhs.uk/haz/news/index.html?id=209

⊕ Dr Bob Gilbertson

⊕ Dr Malcolm Rigler

Central Derby PCT's 'A Public Health Approach A Reality' (PHAAR) is an initiative showing how health visitors and school nurses can work in new and powerful health promotional ways.

http://www.southernderbyshire.nhs.uk/centralderby-pct/phaar_report.pdf

⊕ PCTs;'Central Derby PCT'

Enable protected learning time /cross-locality shut-down events with a regular, rolling programme of training, to include Trailblazer and 'Train the Trainers' courses

'Update' meetings for all primary care teams. Such meetings should place a high emphasis on professionals meeting with service users, other agencies, network and share good work and best practice. Such meetings can be illness or issue specific and be used to challenge mind-sets and forge friendships and partnerships across the locality.

GPs:	• Psychiatry qualification? What? How recent? • Other mental health training? What? How recent? • Skills eg detection, assessment, use of assessment tools, communication, patient education, prescribing, medication management, psychological skills eg counselling, CBT etc, Section 12 training. • Gaps?
Practice nurses:	• Mental health nursing qualification? How recent? • Other mental health training? What? How recent? • Skills e.g detection, assessment, use of assessment tools, communication, patient education, medication management including antidepressants and depot neuroleptics, counselling skills, structured problem solving, anxiety management, brief CBT etc. • Gaps? http://www.primhe.org/downloads/journal/vol_52/newcourses.pdf ⊕ Liz Armstrong http://www.primhe.org/downloads/journal/vol_0041/PCMH005.pdf ⊕ Tony Gillam http://www.primhe.org/downloads/journal/vol_001and2/gardner.pdf ⊕ Sally Gardner
Health visitors:	• Mental health nursing qualification? How recent? • Other mental health training eg detection and management of postnatal depression, use of Edinburgh PND Scale? How recent? http://www.primhe.org/downloads/journal/vol_0041/PCMH004.pdf ⊕ Dr Albert Persaud • Skills eg as above and family support, parent education, counselling skills, structured problem solving, anxiety management, brief CBT etc.
District Nurses:	• Mental health nursing qualification? How recent? • Other mental health training? What? How recent? • Skills eg detection, assessment especially of depression and dementia in older people, communication, patient education, medication management, carer support, psychological skills such as structured problem solving, counselling etc.
Primary Care Counsellors	• Counselling qualification? How recent? Supervision arrangements? • Other primary care training: clinical risk assessment, medication, working to a time limit, confidentiality and the law? • Skill e.g. assessment, empathy goal setting, therapeutic alliance building, effective interventions
Receptionists:	Any mental health training? How recent? Skills eg 'Front of House', customer care, reduction of stigma, handling aggression, recognising people in distress - appropriate referral.
Primary care team:	Team building, understanding of team roles, patient registers, referral criteria, liaison with CMHTs, local authority and voluntary groups, systems and patient pathways, team support/clinical supervision.

Each PHCT should map the skills and training needs in the team and feed the information back to the PCO. Identified training needs which can be used to develop personal learning plans and to plan training for nurses under PREP.

If you have a link worker from the CMHT, they may be able to offer advice on training needs.

Ensure that life-long learning and continuing professional development are embedded in the ethos of the PCO

http://www.targetmedicaleducation.org/menu.htm

http://www.northcumbriahealth.nhs.uk/haz/news/index.html?id=227

Additionally, the PCO can encourage and enable practice based and inter-practice meetings and practice exchanges and 'swaps', so that people can experience other communities and ways of working.

Seek out, nurture, support and develop local champions, such as Trailblazers, those with a declared interest and enthusiasm. Provide leadership and skills programmes

Fund Training

⊕ Trailblazers

http://www.mentalhealth.org.uk/page.cfm?pagecode=PITRCC

http://www.nimhe.org.uk/priorities/champions.asp

http://www.primhe.org

As well as addressing clinical issues around mental health and illness, any training programme would also need to include:

- Stigma and discrimination including knowledge of PCO policies and workplace anti-discrimination issues;

  http://www.rcpsych.ac.uk/press/preleases/pr/pr_406.htm
- Cultural issues including racism; specific local cultural issues and issues around local refugees and asylum seekers. Cultural awareness and culture and mental health should be part of the training programmes for all staff;
- Drug and alcohol misuse including knowledge of local services and support for primary care, together with dealing with aggression;
- Domestic violence and child protection.

Training programmes need to include administrative as well as clinical staff and benefit from being integrated with training for secondary care staff. Interprofessional and multi-agency meetings also provide useful opportunity for people to understand each others work and to grip the possibilities that whole-systems approaches offer. For example, depression, anxiety and schizophrenia impact on inter alia, cardiovascular, diabetes, asthma, rheumatology, cancer, palliation workload and issues - so joint educational and training meetings offer excellent opportunities to tackle such key issues.

The NHS Modernisation Agency has some excellent Leadership Guides

http://www.modern.nhs.uk/improvementguides/process/global_home.htm

http://lifelonglearning.co.uk/index.htm

http://lifelonglearning.co.uk/cltp/index.htm

⊕ LifeLong Learning

7. Mapping local services.

All PCHTs need comprehensive, up to date information about local services, including secondary care services, hospital admission, social services and community services including the voluntary sector. This should be produced at PCO level but practices can build their own database of services.

http://www.primhe.org/downloads/journal/vol_0061/Emberson%20Talbut.pdf

⊕ Canterbury Open Centre

Wall charts showing details of such services have proved useful and can be displayed in consulting/treatment rooms, reception areas and waiting rooms making the information as accessible as possible to both staff and patients. Wall charts could be produced at PCO level and should include, as a minimum, information about what is provided by each service, which each service is for and contact details. Other details such as referral criteria and out of hour's arrangements will also need to be available to all PCHTs.

8. Liaison arrangements.

Referral criteria and contact names for crisis and out-of-hours services should be agreed by PCOs and the appropriate service but all practices need to be aware of arrangements. Liaison arrangements with A&E departments and crisis services for people who self harm also need to be clear to PHCTs. This may require facilitation and training. Some practices will need considerable support.

Closer links should be established with local CMHTs. Partnership and close communication with all individual PHCTs and CMHTs is a central part of the functioning of an integrated service.

http://www.primhe.org/downloads/journal/vol_003/agius.pdf

The following are suggestions on how PHCTs and CMHTs can work more closely together:

1) Development of a shared care agreement. Successful shared care arrangements improve the care of clients. They allow the seamless transfer of patient treatment between primary and secondary care. Shared care agreements can be developed within the practice with the CMHT (See CD-ROM for an example of a shared care agreement)

2) Link Working: A clinician from the CMHT attends the practice on a regular basis to provide support to the team in their care of individuals with severe and enduring mental health problems. They act as a point of liaison between the PHCT and secondary mental health services and can offer advice about the management of mental health problems.

The format depends on the individual needs of a practice, which may include regular meetings and being available for discussion for potential referrals, assisting with the development of practice SMI register.

A link worker tends to be a qualified mental health professional working within the Community Mental Health Team i.e. care manager, community psychiatric nurse, occupational therapist or senior psychiatrist

⊕ Dr Richard Byng; 'Mental Health Link Pack'

⊕ Aislinn Enright;'Shared Care Template'

Notes

Liaise with local black and minority ethnic groups, including refugees and asylum seekers, to ensure services are appropriate and accessible

In primary care, as in other parts of the NHS, the knowledge and competence to manage mental health problems presented by minority groups can sometimes be restricted. People from minority communities are more likely to seek help for their mental health problems through primary care, which is preferred to specialist mental health services. Reasons for this preference might include fear and/or lack of familiarity with specialist services. People from ethnic minority communities are also less likely to make or accept a strict distinction between mental health and physical health problems and the explanatory models relied on by different cultural groups may not be congruous with the explanatory models of Western psychiatry.

Each PCO needs to scope out all the mental health activites in its locality to ensure best communication, both with them and with PHCTs, so that practices are aware of the services available. This especially applies to Home Treatment Teams (HTTs) ⊕ HTA;'Home Treatment'; Assertive Outreach Teams and Early Intervention Teams. Some Trusts are seeing HTTs as mostly interchangeable with crisis intervention services ; others, such as City and Hackney are seeing them as a way of working with families, counsellors, health and social activities to maintain people at home with good quality of life. Contact: Nand Gopal and Mark Travella; phone no - 020 8510 8093.

Each PCO needs to have detailed knowledge of local black and minority ethnic groups, the localities where they mainly live and the GP practices which they use. Effective liaison with local groups will help to ensure that services are appropriate and accessible and will help to inform the commissioning process.

'Building Bridges' is a network funded by the Liverpool Health Action Zone dedicated to providing and working with services that are accessible and appropriate to the needs of black and minority ethnic communities. Details from www.haznet.org.uk (select HAZ Innovation Fund Projects)

The 'Barefoot' Health Workers Project is a community health development research project that has been working with the Bangladeshi, Yemeni and Somali communities in Butetown and Grangetown since February 2001. Members of these communities have participated in activities that have been identified and developed through the action research process.

http://www.wales.nhs.uk/lhg/page.cfm?orgid=262&pid=509

'Starting Well' aims to demonstrate that child health can be improved by offering a programme of home-based activities to support families, and by ensuring parents and children have access to enhanced community based resources. Approximately 900 families are now involved in the Project and it is anticipated that 1800 families will have been helped by Starting Well by November 2003

(NHS Trusts;'Greater Glasgow Primary Care NHS Trust'

http://www.show.scot.nhs.uk/ggpct/clinical/startingwell.htm

Some areas have produced web-enabled discussion for and self-help materials. Northumberland HAZ has worked with the Mental Health Trust

⊕ NHS Trusts; 'Northumberland Mental Health NHS Trust'

http://www.northumberland-haz.org.uk/selfhelp/default.htm

Ensure that practices have access to services for all people who misuse drugs and alcohol

Shared care arrangements for people who misuse drugs and alcohol may be the best way of organising services. Practice policies are useful in helping to ensure consistency of approach. Practices may require help and support to develop such policies from e.g those GpwSIs who have had the formal training.

http://www.nta.nhs.uk/guidance/commissioners/sect_3_6.htm

http://www.primarycare.co.uk/flash/education/Goldman.ppt

Develop and maintain links with all local user and carer groups and work with others to develop resources that will enable and support them

This aspect may be underdeveloped at primary care level. Many areas have good or reasonable liaison with groups representing users of specialist services, but this would need to be extended to include users of primary care services, bearing in mind that around 90% of people with mental health problems use only primary care services. Some practices will have patient liaison groups but may not have addressed mental health issues. Many PCTs will be extending patient and public involvement in their areas as they develop Patient Advocacy and Liaison Services (PALS). Mental health needs to be part of this process.

http://www.nimhe.org.uk/user.asp

http://www.doh.gov.uk/patientadviceandliaisonservices/index.htm

http://www.nelh.nhs.uk/pals/

Develop workplace support and promote mental health in the workplace

Mental health issues for staff need to be addressed systematically at organisational level and include race equality policy and human resource strategies. Workplace issues confront both the providers and users of services and impact on morale, recruitment, retention, treatment outcome and patient experience. Happy teams=happy punters.

The arrival of new primary care workers also offers a key opportunity to ensure that these people themselves are properly supported and supervised. Mental health work, and dealing with those with mental illness, can be exciting, challenging and potentially exhausting. Every PCO must balance its priorities as to how best to deploy new staff to ensure that their wellbeing is catered for.

The PCO can appoint a project manager to develop a mental health in the workplace strategy that meets the needs of the organisation and who can:

- Promote the mental health and well being of all staff and raise awareness about how people can look after themselves and their colleagues;
- Address factors that are affecting mental health in the workplace;
- Develop a programme for giving support to staff returning to work after a mental health problem and which adopts positive, open and accessible employment strategies which are confidential and non-stigmatising;
- Monitor the implementation and effectiveness of the strategy.

The workforce may also provide a 'way in' to the local population - they are part of it.

Mentorship programmes provide valuable emotional support

http://www.nyx.org.uk/mentors/mentoring.html

Balint Groups enable care professionals to discharge the psychological 'static' that builds up as a result of engaging the public

http://www.balint.co.uk/home.html

As part of the employers' strand of the 'mindOUT' campaign, a line-managers pack will shortly be produced. Entitled 'Talking about Mental Health: a practical resource for line managers', the pack will offer advice on managing and supporting people who are experiencing stress, distress and mental health problems.

http://www.mindout.org.uk/

Colchester PCT has produced a toolkit to assess morale in primary care organisations.

www.nhsalliance.org/docs/Morale%20questionnaire.pdf

www.nhsalliance.org/docs/Morale%20solutions.pdf

South and East Dorset PCT, amongst others, have produced human resource and race and equality policies.

http://www.southandeastdorsetpct.nhs.uk/frames/default.asp

There are a number of publications relating to mental health available from the King's Fund, including 'Counting Smiles - workforce motivation and morale in the NHS.

www.kingsfund.org.uk

See also **www.primhe.org** and Hughes S (2002) Mental Health Promotion in the Workplace. Journal of Mental Health Promotion 1:3. 20-26.

http://www.pavpub.com/pavpub/journals/showsub.asp?Section=3&SubSection=4

Develop accessible materials and resources

When thinking about service design and development, it can be helpful to consider those using services as being on a journey. "Imagine yourself as a potential service user or carer" of your own services.

Northumberland HAZ has produced web-enabled self-help guides

http://www.northumberland-haz.org.uk/selfhelp/default.htm

Solihull PCT has a SolihullKids website

http://solihull.dsk.co.uk/solihullkids/index.html

Liaise with other key partners

Partners will include other local PCOs, Trusts, Local Authorities, Voluntary and Community Organisations and Strategic Health Authorities.

http://www.nyx.org.uk/modernprogrammes/mentalhealth/usefulmaterial.html

⊕ Northern and Yorkshire Regional NHS Modernisation Programme

http://www.somerset.nhs.uk/healthyliving/index.html

⊕ NHS Trusts; Somerset Health and Social Care Trust

http://www.herefordshirementalhealth.info/index.shtml

⊕ Herefordshire Mental Health

Address mental health issues in relation to employment status of the local population

Group cognitive behavioural therapy is effective in improving mental health and employment outcomes in unemployed adults. Interventions with a strong focus on job search self-efficacy, social and emotional coping skills and building social support are effective (Price et al 1992). This approach also focuses on positive activities and improving social networks. A number of studies demonstrate the value of social support in reducing the impact of stressful life events, including unemployment (Bloom 1985; Whelan 1993).

In June 2002, the Department for Work and Pensions and the Department of Health jointly funded a one-year Job Retention Pilot. The Job Retention Team (JRT) within the Avon and Wiltshire Mental Health Partnership Trust received this funding to continue providing a free service to employees who are experiencing mental health problems and are at risk of losing their jobs. The JRT provide ongoing support and case management to employees as well as negotiate with their employers about potential workplace adjustments and return to work plans.

http://www.wlp.uk.com

⊕ WLP (Work Life Partnerships);

Notes

GPs need to understand the significance of their certification practices when people ask to be signed off work. Signing people off for long periods can lead to permanent unemployment and disability.

⊕ CBI; Healthcare brief.pdf.

GPs can be advised on how they can change their practice and forge links with agencies who may well be able to help address the needs of their "heart sink" patients.

Contact: Dr Bob Grove, via Andy Bell at the Sainsbury Centre for Mental Health: 020 7827 8353 or 07810 503638.

http://pc22-57.iahsp.kcl.ac.uk/projects/iahsp/programmes/employment/employment.asp

http://www.scmh.org.uk/wbm23.ns4/WebLaunch/LaunchMe

They can also be encouraged to liaise with agencies such as Jobcentre Plus

www.jobcentreplus.gov.uk
⊕ Jobcentre Plus

and invite the CAB

http://www.citizensadvice.org.uk/index.html

⊕ Citizens Advice Bureau
into their practice on a regular basis